



MEDICAL BOARD OF CALIFORNIA
 BOARD OF PODIATRIC MEDICINE
 1420 HOWE AVENUE, SUITE 8
 SACRAMENTO, CA 95825-3229
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CERTIFICATE OF PODIATRIC MEDICAL EDUCATION

This certifies that _____
Full name of Applicant
 of _____ enrolled in _____
Candidate's address when enrolled *Name of Podiatric Medical School*
 _____ on the _____ day of _____
Address of School *Month* *Year*

and was granted the following credits on enrollment:

Prepodiatry Education. Two years of preprofessional postsecondary education, including the subjects of chemistry, biology or other biological sciences, and physics or mathematics (Business and Professions Code Section 2481).

Educational Institution *Dates*

Advanced Credits. Credits previously obtained at an approved podiatric medical school.*

Podiatric Medical School *Total Credits* *Dates*

The undersigned further certifies that the records of this institution show that he/she attended in this institution _____ courses of resident instruction of _____ weeks each (*Specify numbers in the blanks*), completing at least 4,000 hours (of at least 50 minutes each) in the subjects set forth hereunder (Business and Professions Code Section 2483), and
 was granted the degree Doctor of Podiatric Medicine by
 withdrew from
 the above-mentioned podiatric medical school on the _____ day of _____
Month *Year*

SUBJECTS OF INSTITUTION	# of HOURS ATTENDED	SUBJECTS OF INSTITUTION	# OF HOURS ATTENDED
Alcoholism and substance abuse detention		Orthopedic Surgery	
Anatomy, including Embryology, Histology and Neuroanatomy		Pathology, Microbiology and Immunology	
Anesthesia		Podiatric Medicine	
Bacteriology, Infectious disease		Pharmacology, including Materia Medica and Toxicology	
Behavioral science		Physical and Laboratory Diagnosis	
Biochemistry		Physical Medicine	
Biomechanics – Foot and Ankle		Physical Therapy	
Child abuse detection		Physiology	
Dermatology		Podiatric Medicine	
Didactic Podiatry		Podiatric Surgery	
Geriatric Medicine		Preventative Medicine, including Nutrition	
Human Sexuality		Psychiatric problem detection	
Medical ethics		Therapeutics	
Neurology		Women's health	
		Enter Total Number of Hours Completed	_____

Signed and the college seal affixed this _____ day of _____, 20____.

By _____
President, Secretary, Dean

{ SEAL }

**TRANSCRIPTS OF PREPODIATRIC EDUCATION, ADVANCED CREDITS, AND
 PODIATRIC MEDICAL SCHOOL CREDITS MUST BE SUPPLIED WITH THIS CERTIFICATE**

*Each school where professional podiatric instruction was received **MUST** complete one of these forms.
 If more than one school was attended, photocopies of this blank form may be made and used.
 Note that all entries to the form must be original.

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